HIT Policy Committee
DRAFT
Summary of the August 6, 2014 Virtual Meeting

ATTENDANCE (see below)

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the 62nd meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee (FACA) meeting being conducted with an opportunity for public comment (limited to 3 minutes per person), and that a transcript will be posted on the ONC website. After calling the roll, she instructed members to identify themselves for the transcript before speaking.

Remarks

National Coordinator and HITPC Chairperson Karen DeSalvo reminded members that she is reviewing the internal organizational structure to ensure that ONC can meet its demands in the coming years. She mentioned the importance of each of the presentations listed on the agenda. The interoperability plan will be formally submitted for public comment in October. There will be a joint meeting with HITSC in October. A consumer summit will be convened in September.

Review of Agenda

Vice Chairperson Paul Tang also noted each of the items on the agenda, which was distributed by e-mail prior to the meeting. No additions to the agenda were requested. He asked for and received a motion to approve the summary of the July meeting, saying that he and Neal Patterson had submitted corrections to Consolazio. A motion was made by Deven McGraw and seconded by Christine Bechtel to approve the summary report as corrected. The motion was approved unanimously by voice vote.

> **Action item #1: The summary of the July 2014 HITPC meeting was approved unanimously by voice vote.**

Interoperability Updates

Erica Galvez, ONC, gave a slide presentation summarizing definitions of interoperability, the ONC 10-year vision concept paper, and plans for a roadmap with five building blocks and nine guiding principles. She announced that ONC committed to leading the development of a shared, national interoperability roadmap in the 10-year plan concept paper. The roadmap will chart a course toward the vision. It will not be limited to federal government involvement. Its structure will be based on the vision, building blocks, and milestones described in the concept paper. She acknowledged tension among the nine guiding principles. The first version of the roadmap is expected March 2015. Some aspects of roadmap development are already underway, such as the JASON Task Force and the Governance Subgroup. This week ONC is launching an online forum with a general solicitation for input on priorities, use cases, and critical actions within each of the five building blocks. More details on the timeline and other aspects of the roadmap will be presented at the October meeting.

Q and A

Paul Egerman referred to the slide with the definitions of interoperability - the IEEE definition with its two components and then the second, much broader definition that includes individual access to information. He wondered whether this is what the HITPC really wants. Galvez responded that the focus is on the use of information, that is, information that can be put to use for a specific purpose. Egerman expressed concern about providers that do not have health information systems, saying that the roadmap may be making it harder than necessary.

Marc Probst referred to the nine guiding principles, saying that too much may be being undertaken. The first focus should be on interoperability and only then on how to use the information. Empowering individuals is something entirely different. He made a second point: Where is the teeth in this approach? Who will be responsible for enforcement? Galvez acknowledged that the roadmap will be voluntary. ONC will have to collaborate with other entities on levers. She said that she will have to think more about his point. Probst went on to say that similar planning is underway by other organizations; without teeth, there is little point in the endeavor. Tang asked Galvez to address these comments in her presentation in October.

Neal Patterson pointed out that true interoperability cannot occur without the capability to identify patients. There has been considerable investment in local and regional HIEs, what is their future role? Galvez reminded him that patient identification and matching is mentioned in the concept paper. It is critical and will be addressed in the roadmap. HIEs and HIOs are existing assets and they, along with other such assets, will be leveraged in the first 3 years of the cycle. Patterson indicated that he does not necessarily support preservation of HIEs. Galvez informed him that she was not making the assumption that HIEs would or should be preserved, but since they currently exist, they will be used.

Charles Kennedy referred to the definitions of interoperability, saying that they should address both the syntaxic and the semantic. Meaning should be preserved from source to receiving system. Interoperability to what end? There should be a focus on problems to be solved, most importantly, chronic disease management. From a health plan industry perspective, inclusion of families and individuals is essential. Galvez agreed that interoperability is a means to an end, a concept that is explained in the vision paper.

Egerman voiced agreement with Patterson on the HIE infrastructure insofar as the use of existing and proven technology should be a priority.

David Kotz commented that 10 years is a long planning horizon. He suggested that research questions be identified early on so that researchers can begin to work on them. Galvez replied that some questions have already been identified and others will emerge as time goes on.

Troy Seagondollar referred to Probst's comment and observed a tipping point between market forces and regulation on interoperability. He asked about the possibility of regulation to push interoperability. Galvez talked about balance and the reference to the regulatory environment in the fourth building block. She promised to circulate additional material in advance of the discussion at the October meeting.

Tang summarized that many federal agencies, along with the FACAs, will be involved in the road map, which will be the main agenda item for the HITPC-HITSC joint meeting in October. The roadmap is designed to be a collaborate process.

Standards and Technology Updates

Steve Posnack, ONC, did not present slides as he described the open test method pilot program initiated in July. ONC has always had an open door process, meaning that anyone could submit testing tools. But

up through the 2014 Edition, no outside entity submitted materials. Thus, NIST and ONC staffs were solely responsible for the design of procedures, tools, and test data. Many users have criticized the certification and test process and procedures, so staff decided to expand stakeholder involvement in order to improve the methods. The open test pilot is a more bottom-up approach and is open to all. This community of interested stakeholders has selected two certification criteria, e-prescribing and CDS, and is currently evaluating templates and structure for test procedures. Conference calls are being convened and everyone is welcome to participate. The template evaluation will conclude August 15 with the testing tools scheduled for finalization in October. ONC staff will assess the pilot results and determine whether this approach is scalable and appropriate for use in the future.

Q and A

Tang declared that ONC staff was being very responsive to community interests.

McGraw referred to the recent OIG report on testing and certification bodies and asked Posnack whether he had reviewed it. Posnack responded that he had indeed read it and was looking at ways to enhance the public comment process.

Posnack repeated that by the end of October, he expected to have new test procedures for the two certification criteria. Then he will work with the certification bodies and testing facilities to test the methods. 40-50 individuals participated on the most recent information call. He will also work with providers to the extent possible. Anyone can view the process on the web and comment.

Data Review

Vaishali Patel, ONC, showed slides and summarized some of her analyses of data from meaningful use reports, National Electronic Health Record Survey, NCHS Workflow Survey, AHA Health IT Supplement, ONC Survey of Clinical Laboratories, and reports by state HIE program grantees. Prior to stage 2 in 2013, physician exchange activity with outside providers was limited to less than 14%. Hospital exchange activity grew significantly from 41% in 2008 to 62% in 2013. Exchange of data during transitions is limited for EHs and EPs, as evidenced by survey and early stage 2 data. The performance on summary of care and VDT is generally lower than performance of the other stage 2 core measures. In 2012, 5 in 10 physicians received discharge summaries routinely, but only 25% received them electronically. In 2013, 49% of hospitals reported they had the *capability* to send care summaries to an outside organization using a different EHR. A significant number of individuals experience gaps in information sharing though a significant portion of individuals who obtain access to their health information do view, download and share (VDT) their data. About 1/3 of the US adult population reported experiencing at least one gap in the provision of health care information. 28% of the adult population reported having online access to their personal health care information in 2013, but only 40% of them actually viewed the data, with fewer downloading or transmitting those data.

State HIE grantees report increased capabilities for query-based and directed exchange, as well as increased ability to support exchange through the provision of key services. Data show growth in exchange capability and activity, but also show substantial room for improvement. Interoperability measurement will be a key focus in coming months.

Q and A

Tang said that the slides should connect the dots regarding individuals. He wondered why only 28% of individuals report having been offered access to data when most vendors offer patient portals. Patel explained the difference between a population-based survey and a clinic-based survey of patients. In the former, some respondents may not have had a physician visit, among other differences.

Probst asked about difference in interoperability between integrated systems and non-integrated systems. Referring to slide 17, he noted that 18% of respondents said that they had had to provide medical history again because the provider had not gotten records from another provider. Does that mean that 82% of respondents had a good experience? Patel explained that data were not analyzed by integrated-non-integrated systems. However, one slide compared exchange within an organization with exchange outside an organization. For EHs, exchange rates within affiliated hospital systems are higher than exchange rates with unaffiliated hospitals. Probst said that exchange among affiliated components is not much of a problem. The problem yet to be solved is exchange among unaffiliated systems. Patel agreed that more research is necessary to identify barriers. Regarding the 18% of respondents who experienced a problem, she assumed that 82% did not have that problem, although she acknowledged that there may have been missing data. In response to another question from Tang, she said that exchange within system, may or may not have been the same EHR system. That question was not asked. Tang emphasized the importance of sorting this out and obtaining better information.

McGraw reminded members of a report at a previous meeting from the Information Exchange Workgroup on a listening session in which panelists described their experiences with ToC and VDT. She suggested that Patel review the panelists' statements and listen to the session recording in conjunction with the survey data. According to the panelists, low rates of VDT are due less to technical issues than to workflow and trust factors. Patel said that she understood that qualitative data can inform the interpretation of quantitative data as well as the design of future surveys.

Chris Lehmann pointed out that the survey dealt with process not outcome measures. In the future, questions should at least obtain opinions on outcomes if not measurement of outcomes per se.

Bechtel talked at length about two aspects of Patel's report. She agreed with McGraw's suggestion and asked for a follow-up report. She went on to ask for a description of the characteristics of the respondents who experience gaps. She hypothesized that they are the chronically ill who need information the most. She told about a national consumer survey commissioned by her employer. Although the findings have not yet been published, she reported that 49% of respondents had online access to their medical information, a considerable increase from the previous period. 84% of respondents who have online access, said that they use it. Patel compared Bechtel's report with slide 18, which dealt with offered access. She reminded Bechtel that phrasing of survey items and the period of data collection are important considerations in comparing findings. Offered is different from used. And the available stage 2 data are early in the reporting period. Regarding the characteristics of the 18%, she said that staff is analyzing these data. She offered to discuss the surveys with Bechtel offline. Pertaining to slide 18 and VDT, she said that the information had been presented previously by Elizabeth Myers. It shows, for instance, that 40% of attesters performed above 90% and 10% of EP attesters reported that between 15-20% of their patients used VDT.

Someone asked whether the data were reported by patients or providers. Patel responded that her presentation was based on a number of data sources as shown on an initial slide.

Egerman commented on Bechtel's comment. He explained that the survey on which Bechtel reported included a filter question about respondents' knowledge of whether their doctor had an EHR. Bechtel said that the timing also varied. Egerman and Bechtel agreed that the findings from the two surveys on online access are within 5%.

CMS Data Update

Elizabeth Myers, CMS, presented monthly summary slides. As of June, 90% of EHs and nearly 50% of EPs had been paid. Nearly 90% of EPs have registered, indicating high prevalence of awareness of the program. Regarding attestation through August 1, 5365 EPs attested for the 2014 reporting year. 955

are new participants and 1898 attested to stage 2. 322 EHs have attested for 2014; 131 are new participants and 78 attested to stage 2. She encouraged members to familiarize themselves with the many resources available on the CMS website.

Members had no questions.

Public Comment

Diane Jones, American Hospital Association, referred to the CMS slides shown today and at the July meeting. Although progress occurred from July to August, considering the denominator of 4493, only 6% of all hospitals have attested so far in 2014 and only 1.5% have attested to stage 2. At 10 months into the reporting year and 8 weeks until the end of Q4 for the hospitals, she pointed out that the data are concerning and do not support the notion that the program is on track or at least on track to a successful endpoint. Referring to a study by ONC, academic researchers, and the American Hospital Association based on survey data of late 2013 - early 2014, she concluded that progress toward adoption has not been evenly distributed across hospitals. Fewer than 6% of hospitals surveyed were able to meet stage 2 criteria. She urged HHS to finalize quickly the rules relative to flexibility around the meaningful use requirements in the reporting year 2014. Performance on some of the functional objectives and measures is lower than expected, particularly on those requiring data exchange. Consolazio imposed the 3-minute limit.

David Kibbe, Direct Trust, reported on a cooperative agreement with ONC, saying that his data complement other data presented. As of March 31, 4014, the first 19 Direct service providers approved by Direct Trust reported provision of services to 5600 health care organizations and 190,000 Direct accounts and addresses. 3.5 million Direct exchange transactions were reported. Preliminary results for the period ending June 30, 2014 from 30 Direct Trust HISPs indicate service to more than 7500 health care organizations and 400,000 Direct accounts and addresses. He said that most of the activity is associated with stage 2. He said that Direct Trust reports on activity specific to outbound Direct messages from a provider for the purposes of the ToC objective. Consolazio imposed the 3-minute limit.

Kate Horley, Corhio, asked Myers about the attrition rate between stage 1 and 2. Consolazio informed her that public comment was not intended to respond to questions. Myers may respond off-line or at the next meeting.

SUMMARY OF ACTION ITEMS

> **Action item #1: The summary of the July 2014 HITPC meeting was approved unanimously by voice vote.**

Meeting Materials

- Agenda
- Summary of July 2014 meeting
- Presentations and reports slides

Meeting Attendance								
Name	08/06/14	07/08/14	06/10/14	05/08/14	05/07/14	05/06/14	04/09/14	03/11/14
Alicia Staley	X					X	X	
Aury Nagy								

Charles Kennedy	X					X	X	
Chesley Richards	X					X		
Christine Bechtel	X		X			X	X	X
Christoph U. Lehmann	X		X					
David Kotz	X		X			X	X	X
David Lansky	X		X			X	X	X
David W Bates			X			X		
Deven McGraw	X		X			X	X	X
Devin Mann						X		X
Gayle B. Harrell	X		X			X		X
Joshua M. Sharfstein	X					X	X	X
Karen DeSalvo	X		X			X	X	X
Kim Schofield	X		X					
Madhulika Agarwal	X					X	X	X
Marc Probst	X		X		X	X	X	X
Neal Patterson	X		X					
Patrick Conway								
Paul Egerman	X		X	X	X	X	X	X
Paul Tang	X		X	X	X	X	X	X

Robert Tagalicod						X	X	X
Scott Gottlieb			X				X	X
Thomas W. Greig	X		X			X	X	
Troy Seagondolla r	X					X	X	X
Total Attendees	**19**	**0**	**15**	**2**	**3**	**19**	**17**	**18**